

FAX TO : MEDICARE

Georgia : (877) 892-8213	Arkansas: (877)277-1820	Connecticut : (877) 892-8215	Louisiana : (866) 455-6488
Mississippi: (877)277-1820	Illinois: (877) 899-2044	Kentucky: (888) 361-5684	NewYork:(877) 892-8214
Florida : (877) 892-8216	South Carolina: (877)277-1820	New Jersey : (877) 892-8221	Texas:(877)894-2034
			Tennessee: (877)277-1820

FAX TO : MEDICAID

Florida : (800) 935-5752	Georgia : (866) 455-6487	Illinois : (866) 867-9953	Kentucky : (877) 431-0950
Nebraska: (855)-292-0240	New Jersey: (888)342-6548	New York : (800) 246-7983	S Carolina : (888) 344-0376

PRIORITY LEVEL

Standard Post-service

Do not use this form for an urgent request, call (800) 351-8777.

CHECK ONE OF THE FOLLOWING:

<input type="checkbox"/> Ambulatory Surgery	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Lab Services
<input type="checkbox"/> Office visit and/or Procedures	<input type="checkbox"/> Outpatient Hospital Service	<input type="checkbox"/> Radiation Therapy

Required Information: In order to ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, please complete this form in its entirety. Please type or print in black ink and submit this request to the fax number above.

MEMBER INFORMATION

WellCare ID :	Last Name:	First Name, MI:
Medicaid/Medicare # :	Phone Number:	Date of Birth:

REQUESTING PROVIDER INFORMATION

WellCare ID Number:	NPI Number/Tax ID:	
Last Name:	First Name:	
Street Address:	City, State:	Zip Code:
Phone Number:	Fax Number:	
Provider Type/Specialty:	Name of Requester:	

TREATING PROVIDER INFORMATION

<input type="checkbox"/> Out of Network If yes, please provide reason:	
WellCare ID Number:	NPI Number:
Last Name:	First Name:
Street Address:	City, State: Zip Code:
Phone Number:	Fax Number:
Provider Type/Specialty:	Name of Requester:

FACILITY INFORMATION

Type : <input type="checkbox"/> Office <input type="checkbox"/> OP Hospital <input type="checkbox"/> Free Standing Facility	Medical Record Number :
WellCare ID Number:	NPI Number:
Facility Name:	Phone Number: Fax Number:
Street Address:	City, State: Zip Code:

SERVICE REQUESTED

Planned Date of Service : / /		
Primary ICD-10 Code : Description :		
CPT-4 Code(s)	Description(s)	Visits / Frequency

Please include additional procedures code and pertinent Clinical Summary below: (Attach supporting clinical records, if necessary).

*Authorizations will be given for medically necessary services only; it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergencies do not require prior authorization (An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result, without immediate medical attention, in serious jeopardy to the health of an individual). *Urgent Care is defined as medically necessary treatment for an injury, illness, or other type of condition (usually not life threatening) which should be treated within 24 hours.*